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1 Will the mandate drive a culture which puts patients at the heart of everything the NHS does?

Q1.:
The mandate has, as its second objective, putting patients first, after improving our health and our healthcare. We think that, whilst the NHS commissioning Board is right to aim to improve outcomes, then surely putting patients first should be the first and most important objective for the Board if it truly aims to drive a culture which puts patients needs ‘at the heart of everything the NHS does’.

2 Do you agree with the overall approach to the draft mandate and the way the mandate is structured?

Q2.:
We agree with the overall structure of the mandate and are pleased to see that it builds on the NHS Outcomes Framework, around which we are developing improvement areas. Having a mandate that is reviewed yearly, but not changed more often, will help to give continuity to targets. Objective 3, working with other public services, is an important role for the Board.

3 Are the objectives right? Could they be simplified and/or reduced in number; are there objectives missing? Do they reflect the over-arching goals of NHS commissioning?

Q3.:
The objectives do seem to be rather large in number and sometimes could be combined eg Objectives 7 and 8 aiming to reduce health inequalities could be combined . Others would be hard to measure eg Objective 9, that mental health should be on a par with physical health, whilst worthy, is difficult to see how this could be objectively measured. It is important to have objectives where targets can be set that can be clearly seen to have been achieved.

4 What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?

Q4.:
In order to assess progress against the mandate it is important that clear, measurable , achievable objectives are set with a clear time frame to attain them and that these are reported by independent audits using accurate data. Feedback from stakeholders eg Commissioners, is important but objective data in terms of outcomes which are clearly measurable, is also needed.
It is disappointing that the Key measures for assessing progress (Annex B, Chapter 2) contain the figure x for Objectives 1-5 rather than state an explicit quantity. x is meaningless. Objective 2 is attenuated by the footnote 'this is subject to establishing meaningful data and a baseline'. These are critical requirements of all of these aspirations to be of any validity. Objective 6 refers to 'baselines set out in the technical annex': where is this? Thereafter (Objectives 7- 22) with few exception (Objective 10: 'waiting times') the measures are vague, expressed in terms such as 'evidence that they [outcomes] are being met', or 'delivered', 'agreed timetables', 'demonstration of performance'. Explicit measures are almost completely absent, as are criteria for judging 'evidence', 'performance' etc. Great complexity is obvious, huge cost is inevitable. The results may be so open to methodological criticism as to be worthless.

5 Do you have views now about how the mandate should develop in future years?

Q5.:
The present mandate has good ideals but is short on objective, measurable targets that the NHS Commissioning Board can be seen to be performing against. The mandate is grandiose and complex, both legitimate much-voiced criticisms of the reforms and the Act themselves. Complexity creates inefficiency, risk (clinical, fiscal and legal) and all of these things add significantly to cost.

6 Do you agree that the mandate should be based around the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?

Q6.:
The mandate should definitely be based around the NHS Outcomes Framework in order to avoid setting separate objectives for individual clinical conditions. This is essential to having 'joined –up thinking' so the NHS has clearly defined aims.

7 Is this the right way to set objectives for improving outcomes and tackling inequalities?

Q7.:
The challenge for the NHS in the future is coping with an increasing volume of older people with complex health problems that are not able to be treated, and a lot of resource is concentrated on a small proportion of the population. In order for this to be used to maximum benefit it is important to link health with social services and support to carers. The Five domains of the NHS outcomes framework cover this and the improvement areas within these will continue to develop with time. As targets and measures of outcome, including PROMs are developed and used, then outcomes can be compared and inequalities addressed.

8 How could this approach develop in future mandates?

Q8.:
Future mandates could look at those areas where a national approach, rather than one by individual CCGs is needed and, using the NHS outcomes framework as a guide, look for objectives that can only be achieved through a national coordinated programme.

9 Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?

Q9.:
We feel that this does support shared decision-making but that the availability of personal health budgets should depend on the results of the pilots and that the outcome of this should not be pre-judged. It may be that the pilots identify problems with this system that cannot be resolved. We agree that improving information about services will help inform choice and therefore drive improvement as the money follows the patient

10 Do you support the idea of publishing a "choice framework" for patients alongside the mandate?

Q10.:
We feel that this choice framework is very useful for patients to inform them about what choices are and are not available in various situations, how to get information and how to complain if they are not provided with choice.
We do not, however feel that this is an integral part of the mandate and should not be included as an appendix but as a separate document to which links are provided in the mandate document under Objective 12.

11 Does the draft mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

Q11.:
The new framework provides an opportunity to link the NHS to other services. Vulnerable adults and children often present to the NHS and are high users of resource which may be treating the results but not be addressing the underlying problem . We feel that Objective 16 is too specific and that the NHS often identifies people with problems eg children whose skin disease is not treated properly by parents who are not applying prescribed creams, young adults with STIs, disease aggravated by a stressful environment at home where improved links to other services would benefit that person and reduce the need for healthcare.

12 Should the mandate include objectives about how the Board implements reforms and establishes the new commissioning system?

Q12.:
It is important to encourage innovation and flexibility to respond to local Health needs that CCGs are given freedom to develop their roles. This freedom does carry risks and we feel that it is vital that the mandate includes objectives about how this new system is established including the effective management of poor performance and financial risk. It is also important , although not specified in the draft mandate, that there is some accountability for CCGs to ensure that changes in commissioning is done in a fair and transparent manner and that this is not influences by personal financial incentives for CCG members. The mandate should include an objective to ensure that overall provision of care is commissioned and that currently effective services are not destabilized by cherry-picking small areas to make savings.